



HEALTH INSURANCE BENEFITS ARE IMPORTANT.

Here's what you need to know.

To get the most out of your healthcare coverage, you need a solid understanding of how it works. This information sheet highlights key terms and what they mean to your healthcare coverage and out-of-pocket expenses.

How Does Health Insurance Work?

Health insurance – including medical, dental and vision insurance - helps protect you from the high costs of health care in the United States. It can help you pay for doctor visits, hospital stays, prescription drugs, preventive care and more.

A great place to begin is with the different types of healthcare terms: premium, copay, deductible, coinsurance, out-of-pocket maximum, network, balance billing and explanation of benefits. These are all important definitions to know.

- **Premium:** The amount you pay for having health insurance.
- **Copay:** A fixed charge you pay at the time you receive care. Copays vary by type of service or provider. For example, some services at the Purdue University Student Health Center, or PUSH, may require a copayment. You may have a different copay for emergency room services and another one when you get a prescription at the Purdue University Pharmacy. Copays do not count toward meeting your annual deductible.
- **Deductible:** The total amount you pay for services out of pocket in a plan year (can vary between calendar year and academic year) before the health insurance plan begins to pay. After you reach your annual deductible, the insurance company (Anthem, in the case of medical) will share costs with you. That's called coinsurance.
 - **Note:** Some services such as preventive care (routine healthcare that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems) are paid by the plan before the deductible is met. When the plan says "no deductible," it means that you don't have to meet your deductible, and that the amount you spend out of pocket will not apply toward the deductible.
- **Coinsurance:** The amount you pay for covered health care after you meet your deductible. Coinsurance is expressed in percentages. For example, if the plan plays 90 percent of a given charge, 10 percent is your coinsurance.

- **Out-of-pocket maximum:** The most you'll ever pay in a plan year for eligible expenses. Your deductible, coinsurance and copays all count toward your out-of-pocket maximum. If you reach your out-of-pocket maximum, the health plan will pay 100 percent of your covered expenses. This does not include your monthly premiums or anything you spend for excluded services (ones your plan doesn't cover).
- **Network:** The facilities, providers and suppliers who have signed a contract with a health plan to provide health care services to its members. Also referred to as participating or in-network providers. You will save time and money – with less hassle – if you choose providers who are in-network. You also are protected from balance billing and will not have to fill out and submit claim forms when using in-network providers. Out-of-network providers don't have a contract with the health plan which results in members paying more of the cost when receiving care.
- **Balance Billing:** When you use an out-of-network provider and there is a difference between the provider's charge and the amount your health insurance allows, the provider may bill you for the balance. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider may not balance bill you for covered services.
- **Explanation of Benefits (EOB):** A notice sent from the health plan to the member describing the resolution of a claim. It includes services provided, amount billed, allowed amount (maximum amount a health plan will pay for a covered service), any discounts, payment made by the health plan, and any costs that are the member's responsibility. The EOB is not a bill and is for your information only; the provider will send you a bill separately if you owe an amount. Comparing the EOB to the bill is a good way to make sure you're being billed correctly.

What Do I Need to Do before Getting a Service?

When you're in need of healthcare services, it is best to search for an in-network provider to limit your out-of-pocket expenses. Make sure the service is covered and not limited by or excluded from your plan by reviewing your benefits. Have your insurance card readily available at the time of service. Review the "Questions" section below for useful resources.

When Do I Pay for Services?

Some services require up-front payment – such as an office visit with a copay or filling a prescription. Other services – such as x-rays and hospital stays – will first be processed by your insurance and then you will receive an invoice from your provider for the amount you owe.

Questions?

For more information and support specific to your health insurance, please refer to your benefits websites:

[Academic HealthPlans \(AHP\)](#)

Here you will find benefits information on the domestic and international student and graduate staff medical insurance plans, contact information for Anthem Blue Cross Blue Shield – the insurance carrier – as well as information on portal registration, payment of premiums and enrollment in the medical insurance plans.

[Human Resources - Graduate Staff Benefits](#)

Here you will find information on graduate staff benefits – including medical, vision and dental plans along with other voluntary benefits, voluntary retirement savings plans and leaves. Additionally, information on eligibility, enrollment through Benefitfocus and benefits-related payroll deductions is included.

STUDENT

Open Enrollment

July 1 through September 8
ends 5 p.m. ET September 8

GRADUATE STAFF

Open Enrollment

July 1 through September 8
ends 5 p.m. ET September 8

Your benefits. Your choices. Your well-being.